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F 000	INITIAL COMMENTS An abbreviated standard survey (KY16798) was conducted on 07/27-29/11. The allegation was substantiated. Immediate Jeopardy was identified to exist from 04/07/11 through 06/22/11. On 04/07/11, at 2:00 AM, Resident #1 was noted to have bright red rectal bleeding and continued to have rectal bleeding until being transported to the hospital 24 hours later, on 04/08/11, at 2:15 AM. However, the physician was not notified of the significant change in the resident's condition. Resident #1 was observed to have a large amount of hard stool and three "Soap Suds" enemas, one "Fleets" enema, and "Citrate of Magnesium" were administered to the resident, without a physician's order, during this same 24-hour timeframe. Resident #1 was admitted to the hospital on 04/08/11, with rectal bleeding and received a blood transfusion upon admission to the hospital. The resident experienced severe rectal bleeding on multiple occasions during the hospitalization, and documentation revealed several attempts were made to repair rectal tears and rectal ulcers. On 04/26/11, Resident #1 experienced cardiac/respiratory failure, was intubated, and placed on a mechanical ventilator. The resident was extubated after showing no favorable response on the ventilator, experienced extreme worsening of rectal bleeding, and expired on 05/07/11. The facility Administrator became aware of an allegation of neglect on 04/13/11, when an investigation was initiated by the Department for Community Based Services (DCBS) related to Resident #1. At that time, the facility initiated an investigation and developed a timeline of events. However, the Administrator failed to report the allegation of neglect to all	F 000	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 appropriate state agencies. After becoming aware of the incident, the facility immediately developed and implemented interventions from 04/14/11-06/21/11, to correct the deficiencies. It was determined the facility had completed all corrective actions prior to the State Agency initiating the investigation on 07/27/11, thus resulting in a determination of Past Jeopardy.	F 000		
F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

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F 157	Continued From page 2 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to have an effective system to ensure staff immediately notified the resident's physician when the resident experienced a significant change in condition for one of nine sampled residents (Resident #1). The facility failed to ensure staff followed the Changes in a Resident's Condition or Status policy/procedures to ensure the resident's physician was notified immediately when the resident experienced a significant change in condition. On 04/07/11, at 2:00 AM, Resident #1 experienced a significant change in condition of rectal bleeding and continued to have rectal bleeding at the time of transfer to the hospital 24 hours later on 04/08/11, at 2:15 AM. The facility staff failed to notify the resident's physician of the resident's rectal bleeding. Resident #1 was hospitalized on 04/08/11, diagnosed with rectal bleeding due to a rectal tear, and expired at the hospital on 05/07/11. The facility's failure caused, or is likely to cause, serious injury, harm, impairment, or death to residents in the facility, to include Resident #1. The Immediate Jeopardy was determined to exist on 04/07/11, and continued until 06/22/11. The facility implemented corrective action which was completed prior to the State Agency's investigation on 07/27/11, thus it was determined	F 157	Past noncompliance: no plan of correction required.	

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F 157	Continued From page 3 Past Jeopardy. The findings include: A review of the facility's Changes in a Resident's Condition or Status policy/procedure, dated 01/09/03, revealed Nursing Services was responsible to notify the resident's attending physician when: a) The resident was involved in any accident/incident that resulted in injury, including injuries of unknown source; b) There was a significant change in the resident's physical, mental, emotional or psychosocial status; c) The resident refused treatment/medication; d) There was a need to alter the resident's treatment significantly; e) A decision had been made to transfer/discharge the resident from the facility without proper medical authority; and/or f) Deemed necessary/appropriate in the best interests of the resident. A review of Resident #1's medical record revealed the facility admitted the resident on 01/19/10. Review of Resident #1's medication orders revealed the resident received Aspirin 325 milligrams (mg) once a day and Plavix 75 mg once a day (anti-platelet agents used to inhibit blood clotting). Review of Resident #1's nurse's note dated 04/07/11, at 2:00 AM, revealed Licensed Practical Nurse (LPN) #2 was summoned to the shower room due to Resident #1 having bright red rectal bleeding. The note revealed Resident #1 was placed onto the bed, checked for a rectal impaction which revealed a large amount of hard stool, and staff administered a "Soap Suds"	F 157		

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enema with "small" results noted.

Review of the nurse's note dated 04/07/11, at 2:35 AM, revealed the resident had not had a bowel movement and the resident's rectum was "gapped open" with "some blood clolts (clots) noted." The note further revealed a "Fleets" enema was administered by LPN #2.

Review of Resident #1's nurse's note dated 04/07/11, at 2:05 AM, revealed LPN #2 administered one-half of a bottle of "Citrate of Magnesia" through the resident's Gastrostomy tube (G-tube). The note documented the resident's blood pressure was 88/57, the resident's pulse was 120, and the resident's respiration was 18. Continued review of the nurse's notes dated 04/07/11, from 7:00 AM-7:00 PM documented by LPN #1, revealed the LPN assisted the State Registered Nurse Aide (SRNA) to place the resident on his/her left side. The note revealed staff observed the resident's rectum to have "bleeding (spots)," and a "Soap Suds" enema was administered which, based on documentation, "loosened feces enough to start pushing out" a small bowel movement. The documentation revealed Resident #1 continued to have rectal bleeding at 2:00 PM, "from enema."

Review of the nurse's note dated 04/07/11, at 9:30 PM, seven and one-half hours after the previous note, revealed LPN #2 was summoned to Resident #1's room, and observed Resident #1 to have "rectal bleed mod amount of blood note rectum gaped open, try to pass stool." The note revealed LPN checked the resident for an impaction and a large amount of soft to hard stool was noted in the resident's lower bowel. Based

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on documentation, LPN #2 administered a "Soap Suds" enema to the resident and "medium" results and "bright red" bleeding from the resident's rectum were noted.

Further review of the nurse's note dated 04/08/11, at 1:45 AM, revealed Resident #1 was "having large amount of blood clolts, pad saturated." At 2:15 AM on 04/08/11, 30 minutes after LPN #2 observed Resident #1 had "bright red" rectal bleeding, the resident was transported to the local hospital for evaluation of the rectal bleeding.

The review of Resident #1's medical record revealed no documented evidence that facility staff attempted to notify the resident's physician of the significant change in the resident's condition from 04/07/11, at 2:00 AM, until 04/08/11, at 2:15 AM, when the resident was transported to the hospital.

An interview conducted on 07/27/11, at 5:20 PM, with Licensed Practical Nurse (LPN) #2, revealed Resident #1's physician was not notified of the resident's rectal bleeding because the physician was out of state and according to the LPN, would have instructed her to administer an enema and monitor the resident, which she had done. The interview revealed the LPN reported Resident #1's rectal bleeding and hard stool to the LPN (LPN #1) who worked the following shift.

An interview conducted on 07/27/11, at 6:21 PM, with LPN #1 revealed on 04/07/11, during rounds LPN #2 did not report that Resident #1 had experienced rectal bleeding during the night. The interview revealed LPN #1 went to Resident #1's room on 04/07/11, and the resident was

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attempting but unable to have a bowel movement, and LPN #1 and SRNA #2 attempted to administer an enema to the resident to enable the resident to have a bowel movement. However, LPN #1 stated the tip of the enema syringe could not be inserted into the resident's rectum due to the hardened stool. LPN #1 stated at around 2:00 PM, Resident #1 had another medium bowel movement and a "few spots" of blood were observed at that time. The interview revealed LPN #1 failed to notify the physician of Resident #1's change in condition.

An interview conducted on 07/27/11, at 10:17 PM, with State Registered Nurse Aide (SRNA) #5 revealed on 04/07/11, LPN #2 administered the "Soap Suds" enema and following the enema, the resident was observed by SRNA #5 to have "little meaty clots of blood," and SRNA #5 reported the clots of blood to LPN #2. On 04/08/11, the SRNA stated she observed Resident #1 to be in a "large pool of blood, really meaty," and reported the resident's condition to LPN #2. The interview revealed LPN #2 checked Resident #1 and said the resident would "be all right." SRNA #5 stated she reported the resident's condition to LPN #4, who assessed Resident #1 and said the resident needed to be transferred to the hospital for further assessment/treatment.

An interview conducted on 07/28/11, at 9:20 AM, with LPN #4 revealed an SRNA reported to him that Resident #1 was bleeding; he assessed the resident and observed a moderate amount of bright red blood in the resident's incontinence brief. The LPN stated Resident #1 was transferred to a hospital for further treatment.

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An interview conducted on 07/27/11, at 5:05 PM, with the Director of Nursing (DON), revealed it had always been the facility's policy to notify the physician of any change in a resident's condition. According to the DON, if a nurse was unable to reach the physician the nurse should transfer the resident to the hospital for evaluation or "when in doubt, send them out." The interview revealed LPN #2 should have notified the physician on 04/07/11, at 2:00 AM, when Resident #1 first exhibited the bright red rectal bleeding.

Interviews conducted on 07/28/11, at 12:05 PM, and at 4:00 PM, with Resident #1's Primary Physician, confirmed the Physician was out of town the week the incident related to Resident #1 occurred. The Physician reported he had telephoned the facility twice a day, every day, to receive report of any problems/concerns related to the residents. In addition, the interview revealed the physician was in practice with two other physicians who were "on-call" when the physician was out of town/unavailable. Resident #1's Primary Physician confirmed he had not been informed Resident #1 experienced rectal bleeding and was transported to the hospital until the following week. The Physician stated he would have expected the nurse to report if a resident experienced bright red rectal bleeding and that the resident would be transported to the hospital for evaluation. The interview also revealed the administration of Aspirin and Plavix increased the resident's risk for bleeding, and would have been even more reason to report the rectal bleeding to the physician.

A review of a Hospital Discharge Summary dated 05/26/11, revealed Resident #1 was admitted on

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04/08/11, due to rectal bleeding. The summary revealed the resident immediately received a blood transfusion due to Hemoglobin (HGB) level of 8.0 (reference range 13.5-18.0) and Hematocrit (HCT) of 26.9 (reference range 02-52). On 04/11/11, three days after admission, a colonoscopy was performed and revealed "the anal verge was full of a large amount of blood in the rectum which was removed," "an ulcer on the inferior surface of the rectum about 2 cm without any clot," and "active bleeding coming from the posterior surface of the rectum which was a large tear in the rectal wall measuring 1 X 2 cm" (cm = centimeter, which is about the size of a black key on a piano). The review revealed on 04/26/11, Resident #1 developed Acute Bradycardia (slow heart rate under 60 beats per minute) and suffered cardiac/respiratory arrest, was intubated, and placed on a mechanical ventilator. The summary revealed Resident #1 expired on 05/07/11.

*The facility implemented the following actions to correct the deficiency:

-All of the residents' medical records were audited by the Director of Nursing (DON) and Administrator on 04/22/11, for significant change and to ensure the physician was notified if a significant change had occurred.

-The facility in-serviced all licensed staff on 04/15/11 and 05/04/11, regarding the policy to notify the residents' physician if the residents experienced a change in condition.

-On 04/22/11, the facility initiated a monitoring system to review the 24-hour shift report and new

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physician's orders to ensure the physicians were notified of any changes in the residents' condition. This monitoring was conducted daily by the DON (Monday-Friday) and the Registered Nurse (RN) in charge (in the absence of the DON) on Saturday and Sunday. This monitoring will be ongoing.

-On 05/03/11, the DON, Administrator, Minimum Data Set (MDS) Coordinator, and Social Services Director (SSD) began a daily review of the 24-hour shift reports and new physician's orders to identify any resident with a change in condition and ensure the physician had been notified. This monitoring will be ongoing.

-Beginning 05/03/11, a weekly quality of care meeting was held every Thursday, consisting of all department heads, to review such things as change of condition to ensure the physician was notified. This monitoring will be ongoing.

**The surveyor validated the corrective action taken by the facility as follows:

Interview with the DON and Administrator on 07/29/11, at 4:02 PM, revealed they had audited all resident records related to physician notification/significant change in condition and found no discrepancies. Record review of eight residents' medical records revealed appropriate physician notification.

Review of facility in-services conducted on 04/15/11 and 05/04/11, revealed all licensed staff was in-serviced on physician notification when a resident had a change in condition. Interviews on 07/29/11, at 4:02 PM, with the DON; on 07/27/11,

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F 157	Continued From page 10 at 6:40 PM, with Licensed Practical Nurses (LPN) #3; on 07/28/11, at 9:10 AM, with RN #1; and on 07/28/11, at 9:20 AM, with LPN # 4, revealed they each had attended an in-service on physician notification of a resident's change in condition. Interviews on 07/29/11, at 4:02 PM, with the DON and at 2:05 PM, with Registered Nurse (RN) #2 (the weekend charge nurse), revealed they reviewed the shift report and new physician's orders. Following the reviews, the DON or charge nurse made rounds to identify/assess residents with problems to ensure any change of condition had been reported to the physician. Review of the meeting minutes and interview on 07/29/11, at 4:02 PM, with the DON, Administrator, and MDS Coordinator revealed they meet daily to review the 24-hour shift report and new physician orders to ensure the physician was notified of any resident with a change of condition. Review of the meeting minutes and interview on 07/29/11, at 4:02 PM, with the DON, Administrator, and MDS Coordinator revealed they meet weekly in a quality of care meeting and physician notification of changes in a resident's condition was included in their discussion. Review of minutes from the facility's meeting and interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed they had a quality of care meeting, on a weekly basis, to discuss any resident who had experienced a change of condition and ensure the Physician was notified.	F 157		
F 224	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIAT	F 224		

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F 224	Continued From page 11 N The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy, it was determined the facility failed to have an effective system to implement policies/procedures that prohibit neglect of residents for one of nine sampled residents (Resident #1). The facility failed to ensure staff followed the Resident Protection policy/procedure to ensure residents received the necessary services to avoid physical harm. On 04/07/11, at 2:00 AM, Resident #1 experienced rectal bleeding and continued to have rectal bleeding until transferred to the hospital on 04/08/11, at 2:15 AM. Facility staff neglected to seek treatment/evaluation for the resident's rectal bleeding for 24 hours. Resident #1 was hospitalized on 04/08/11, diagnosed with rectal bleeding due to a rectal tear, and expired at the hospital on 05/07/11. The failure to seek medical attention for a resident has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. The Immediate Jeopardy was determined to exist on 04/07/11, and continued until 06/22/11. The facility implemented corrective actions which were	F 224	Past noncompliance: no plan of correction required.	

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completed prior to the State Agency's investigation on 07/27/11, thus it was determined Past Jeopardy.

The findings include:

A review of the facility's Resident Protection policy/procedure (no date) revealed the facility would review the daily nursing report forms (shift report), conduct nursing rounds, and make routine observations to identify the potential for neglect. The policy stated the abuse/neglect prevention programs included monitoring of staff on all shifts to identify inappropriate behaviors toward residents. The review revealed the facility would assess, care plan, and monitor residents with needs and behaviors that may lead to neglect. According to the policy, neglect was the failure to provide services necessary to avoid physical harm.

A review of the facility's shift report for the 7:00 PM-7:00 AM shift on 04/06/11-04/07/11, revealed Resident #1 had rectal bleeding and was administered an enema. The shift report for the 7:00 AM-7:00 PM shift on 04/07/11, revealed a "Soap Suds" enema was administered at 10:30 AM, with a small amount of bowel movement and at 2:30 PM, the resident had a medium bowel movement. However, the shift report failed to accurately detail the number of enemas administered or the extent of the resident's rectal bleeding.

Review of Resident #1's nurse's note dated 04/07/11, at 2:00 AM, revealed Licensed Practical Nurse (LPN) #2 was summoned to the shower room due to Resident #1 having bright red rectal

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bleeding. Documentation on 04/07/11, at 2:35 AM, revealed the resident's rectum was "gapped open" with "some blood clolts (clots) noted." Continued review revealed LPN #1 documented on 04/07/11, on the 7:00 AM-7:00 PM shift, that the resident's rectum was "bleeding (spots)." The documentation revealed Resident #1 also had bleeding at 2:00 PM, after an enema had been administered. During the following shift on 04/07/11, a nurse's note revealed at 9:30 PM, LPN #2 was summoned to Resident #1's room, and the resident was observed to have "rectal bleed mod amount of blood note rectum gaped open, try to pass stool." LPN #2 documented administration of a "Soap Suds" enema with medium results noted and that Resident #1 continued to have bleeding "bright red in color," from the rectum. On 04/08/11, at 1:45 AM, Resident #1 was observed to have a "large amount of blood clolts" and the resident's pad was "saturated." The review of Resident #1's medical record from 04/07/11, at 2:00 AM, until 04/08/11, at 2:15 AM, revealed no documented evidence that facility staff attempted to seek treatment for Resident #1's rectal bleeding during the timeframe of 24 hours. The review revealed Resident #1 was transported to the local hospital for evaluation of rectal bleeding on 04/08/11, at 2:15 AM.

An interview conducted on 07/27/11, at 10:17 PM, with State Registered Nurse Aide (SRNA) #5 revealed on 04/07/11, the SRNA took Resident #1 to the shower and blood started "dripping" onto the floor of the shower room. The SRNA reported the bleeding to LPN #2. The interview revealed LPN #2 administered a "Soap Suds" enema and, following the enema, the resident

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was observed to have "little meaty clots." The SRNA stated she found the resident in a "large pool of blood, really meaty" on 04/08/11, and reported the resident's condition to LPN #2. The interview revealed LPN #2 checked Resident #1 and voiced no concerns related to the resident's condition. The SRNA also reported the resident's condition to LPN #4. According to SRNA #5, LPN #4 assessed Resident #1 and determined the resident needed to be transferred to the hospital.

An interview conducted on 07/27/11, at 5:20 PM, with Licensed Practical Nurse (LPN) #2, confirmed SRNA #5 reported to the LPN on 04/07/11, at approximately 2:00 AM, that Resident #1 was having rectal bleeding while the resident was in the shower room. According to the LPN, Resident #1 was also observed to have hardened stool in the rectum and an enema was administered. According to LPN #2, the resident was observed to have "a speck or two" of bleeding after the enema. LPN #2 verified Resident #1's physician was not consulted concerning the resident's rectal bleeding. The interview revealed the LPN reported Resident #1's rectal bleeding and hardened stool in rounds to the oncoming LPN (LPN #1) on 04/07/11, at approximately 7:00 AM, and documented the occurrence on the shift report. LPN #2 stated when she returned to work at 7:00 PM on 04/07/11, she received no information from the LPN that had worked on 04/07/11, from 7:00 AM-7:00 PM, that Resident #1 continued to experience rectal bleeding.

An interview conducted on 07/27/11, at 6:21 PM, with LPN #1 revealed at the beginning of her shift on 04/07/11, at approximately 7:00 AM, she

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received a verbal report from LPN #2 and that LPN #2 had reported nothing about Resident #1 experiencing rectal bleeding. LPN #1 stated at approximately 2:00 PM, Resident #1 had a medium bowel movement and had a "few spots" of blood due to the stool being so hard.

An interview conducted on 07/28/11, at 9:20 AM, with LPN #4, confirmed a SRNA had reported to him that Resident #1 was bleeding; he assessed the resident and observed a moderate amount of bright red blood on the resident's incontinence pad.

Interviews conducted on 07/28/11, at 12:05 PM and 4:00 PM, with Resident #1's Primary Physician revealed he was out of town during the week the incident occurred with Resident #1, but had telephoned the facility twice a day, every day, to receive report of any problems/concerns related to the residents in his care. The physician stated he would have expected the nurse to report any incidents of a resident experiencing bright red rectal bleeding and stated in the event of bleeding the resident would have been transported to the hospital for evaluation. The interview revealed the administration of Aspirin and Plavix increased the resident's risk for bleeding and would have been even more reason to report the resident's rectal bleeding to the physician. The interview revealed, in the physician's opinion, the failure of staff to consult the physician concerning the resident's rectal bleeding was neglectful and delayed the resident's treatment.

A review of a Hospital Discharge Summary dated 05/26/11, revealed Resident #1 was admitted to

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F 224	Continued From page 16 the hospital on 04/08/11, due to having rectal bleeding for two days. The summary revealed upon admission the resident immediately received a blood transfusion. Continued review revealed on 04/11/11, a colonoscopy was performed and revealed an ulcer and "active bleeding coming from the posterior surface of the rectum which was a large tear in the rectal wall measuring 1 X 2 cm" (cm = centimeter). The review revealed on 04/26/11, Resident #1 developed Acute Bradycardia (slow heart rate), suffered cardiac/respiratory arrest, was intubated, and placed on a mechanical ventilator. The summary revealed Resident #1 expired on 05/07/11. Interviews conducted on 07/28/11, at 10:10 AM, at 12:30 PM, and at 3:20 PM, with the Vice President of Clinical Operations, the Director of Nursing (DON), and the Administrator revealed every morning, Monday through Friday, the DON conducted a "stand up" meeting with the nurses, reviewed the 24-hour shift report and performed "rounds" to observe all residents and assess any residents that were identified to have "problems." According to the DON, during the review and "rounds" the DON was to ensure the appropriate care/services were provided to address identified concerns and to ensure the physician was notified, if indicated. The interviews revealed the DON was on vacation the week of the incident related to Resident #1, and according to the Vice President of Clinical Operations, the failure was the facility did not have a "back-up" system in place to cover the morning "stand up" meeting, review of the shift report, and making rounds in the DON's absence.	F 224		

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*The facility implemented the following actions to correct the deficiency:

-All resident records were audited by the Director of Nursing (DON) and Administrator on 04/22/11. No concerns were found during the audit related to abuse or neglect.

-All licensed nursing staff and certified nursing staff was in-serviced on 06/03/11, and again on 06/21/11, regarding abuse, neglect, and misappropriation.

-On 05/03/11, as part of the facility's ongoing quality assurance program, the 24-hour nursing reports and new physician's orders were reviewed daily in a meeting with the DON, Administrator, Minimum Data Set (MDS) Coordinator, and Social Services Director. The reviews were conducted to identify any resident with a change in condition, to assure the physician was notified in the event of a change in a resident's condition, and that appropriate care/services were provided for residents to ensure the residents' needs were not neglected. This monitoring will be ongoing.

-A quality of care meeting is held weekly, every Thursday, to review any resident with a change in condition, and to ensure the residents have received the necessary care and services. The meetings began on 05/03/11, and will be ongoing.

**The surveyor validated the corrective action taken by the facility as follows:

Interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed 100 percent of the

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residents' medical records were audited and no concerns were identified related to abuse, neglect, or misappropriation of resident property. Record review of eight residents' medical records revealed no neglect occurred.

Review of facility in-service conducted on 06/03/11, with Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Medication Technicians (CMTs), revealed these staff members were in-serviced on the abuse/neglect policy. Review of the facility in-service on 06/21/11, with State Registered Nurse Aides and three other facility staff members revealed they had been in-serviced on the abuse/neglect policy. Interviews with SRNA #1 on 07/27/11, at 3:15 PM; LPN #3 on 07/27/11, at 6:40 PM; RN #1 on 07/28/11, at 9:10 AM; LPN #4 on 07/28/11, at 9:20 AM; SRNA #2 on 07/28/11, at 2:57 PM; and SRNA #4 on 07/28/11, at 3:15 PM, revealed they had been in-serviced on the abuse/neglect policy.

Interview with the DON, the Administrator, and the MDS Coordinator on 07/29/11, at 4:02 PM, and a review of quality of care meeting minutes revealed they meet daily to review the 24-hour nursing reports and new physician's orders to monitor residents' change of condition/physician notification to ensure the necessary care/services were provided and no neglect occurred.

Review of minutes from the facility's meeting and interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed they had a quality of care meeting, on a weekly basis, to discuss any resident who had experienced a change of condition and ensure appropriate care was

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F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility investigation review, and facility policy review, it was determined the facility failed to have an effective system to ensure all alleged violations involving neglect were thoroughly investigated and reported immediately to the Administrator and to the appropriate state agencies for one of nine sampled residents (Resident #1). The facility failed to ensure staff followed the Resident Protection policy/procedure to ensure alleged neglect was reported immediately and thoroughly investigated. The facility staff failed to provide the necessary care/services for Resident #1 during a 24-hour timeframe, after the resident was observed to have rectal bleeding. Resident #1 was hospitalized on 04/08/11, diagnosed with rectal bleeding due to a rectal tear, and expired at the hospital on 05/07/11. Interviews revealed several staff members had been aware that Resident #1 had experienced rectal bleeding and the necessary care had not been provided; however, the staff members did not report the incident to administrative staff. The Administrator became aware of an allegation of neglect on 04/13/11, when the Department for Community Based Services (DCBS) initiated an investigation of alleged neglect related to Resident #1. The Administrator failed to thoroughly investigate and failed to report the neglect allegation to all appropriate state agencies. The facility's failure caused, or is likely to cause, serious injury, harm, impairment, or death to	F 225	Past noncompliance: no plan of correction required.	

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residents in the facility. The Immediate Jeopardy was determined to exist on 04/07/11, and continued until 06/22/11. The facility implemented corrective actions which were completed prior to the State Agency's investigation on 07/27/11, thus it was determined Past Jeopardy had existed.

The findings include:

A review of the facility's Resident Protection policy/procedure (no date) revealed any alleged violations of neglect must be reported to the Administrator or the DON immediately. The policy stated any person who has knowledge or reason to believe that a resident had been a victim of neglect shall report the offense. According to the policy, neglect was the failure to provide goods/services necessary to avoid physical harm or mental anguish/illness. Neglect occurs on an individual basis when a resident receives a lack of care in one or more areas, according to the policy. The review revealed upon receiving a report of neglect the Administrator or the DON will immediately report the incident to the following agencies: Division of Licensing and Regulation, Adult Protective Services, and other agencies as appropriate. According to the policy, the investigation shall consist of the following: a) A review of the completed Incident Report Form; b) An interview with the person(s) reporting the incident; c) Interviews with any witnesses to the incident; d) An interview with the resident; e) A review of the resident's medical record; f) An interview with staff members (on all shifts) having contact with the resident during the period of the alleged incident; g) Interviews with the resident's

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roommate, family members, and visitors; and h) A review of all circumstances surrounding the incident. The policy revealed employees accused of participating in the alleged abuse/neglect will be suspended without pay until the findings of the investigation have been reviewed by the Administrator. The review revealed the results of the investigation will be recorded on the Resident Abuse Investigation Report form.

Review of the facility's investigation related to Resident #1, with no date, revealed the facility had developed a timeline of events related to the incident but failed to document interviews with the staff involved, as per the facility's policy. In addition, the facility failed to document all state agencies had been notified of the allegation in accordance with the facility's policy.

A review of Resident #1's nurse's note dated 04/07/11, at 2:00 AM, revealed Resident #1 had rectal bleeding that was described as "bright red." The nurse's note dated 04/07/11, at 2:35 AM, revealed the resident's rectum was "gapped open" with "some blood clolts (clots) noted." A nurse's note dated 04/07/11, on the 7:00 AM-7:00 PM shift, revealed the resident's rectum had "bleeding (spots)." The same note revealed Resident #1 still had some bleeding at 2:00 PM, after an enema had been administered. The next nurse's note dated 04/07/11, at 9:30 PM, revealed Resident #1 was observed to have "rectal bleed mod amount of blood note rectum gaped open, try to pass stool." LPN #2 documented administration of a "Soap Suds" enema with medium results noted and that Resident #1 continued to have "bright red" bleeding from the rectum. The next nurse's note

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dated 04/08/11, at 1:45 AM, revealed Resident #1 had a "large amount of blood clolts," and that the resident's underpad was "saturated." The review revealed Resident #1 was transported to the local hospital for evaluation of rectal bleeding on 04/08/11, at 2:15 AM.

An interview conducted on 07/27/11, at 10:17 PM, with State Registered Nurse Aide (SRNA) #5 revealed on 04/07/11, Resident #1 had blood "dripping" onto the floor of the shower room, and the SRNA reported the resident's bleeding to LPN #2. The interview revealed LPN #2 administered an enema and following the enema, the resident was observed to have "little meaty clots." The SRNA stated on 04/08/11, Resident #1 was found in a "large pool of blood, really meaty," and she reported the resident's condition to LPN #2. The interview revealed LPN #2 stated the resident would "be all right." SRNA #5 stated she then reported the resident's condition to LPN #4. According to SRNA #5, LPN #4 assessed Resident #1 and the resident was transported to the hospital.

An interview conducted on 07/27/11, at 5:20 PM, with Licensed Practical Nurse (LPN) #2, confirmed on 04/07/11, at around 2:00 AM, SRNA #5 reported Resident #1 was having rectal bleeding. The interview revealed the nurse checked the resident and observed a "speck or two" of blood. The LPN stated on 04/08/11, the SRNAs reported Resident #1's rectal bleeding to LPN #4, who then reported the bleeding to LPN #2 and the resident was transported to the hospital on 04/08/11.

An interview conducted on 07/28/11, at 9:20 AM,

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with LPN #4, revealed an SRNA reported to him that Resident #1 was bleeding. The LPN stated he assessed the resident and observed a moderate amount of bright red blood in the resident's incontinence brief.

An interview conducted on 07/27/11, at 9:05 PM, with SRNA #2 revealed Resident #1 received a "Soap Suds" enema on 04/07/11. According to the SRNA, she observed spots of blood from the resident's rectum, stopped the enema, and reported the bleeding to LPN #1.

A review of a Hospital Discharge Summary dated 05/26/11, revealed Resident #1 was admitted to the hospital on 04/08/11, for having rectal bleeding for two days. The summary revealed the resident immediately received a blood transfusion upon admission. On 04/11/11, a colonoscopy was performed and revealed an ulcer and active bleeding coming from a large tear in the rectal wall. The review revealed on 04/26/11, Resident #1 developed a slow heart rate, suffered cardiac/respiratory arrest, and expired on 05/07/11.

Interviews conducted on 07/28/11, at 10:10 AM, at 12:30 PM, and at 3:20 PM, with the Vice President of Clinical Operations, the Director of Nursing (DON), and the Administrator revealed the Administrator and DON became aware of the allegation of neglect when a representative from DCBS initiated an investigation on 04/13/11. The interview revealed after reviewing Resident #1's medical record and interviewing the staff involved, it was determined LPN #1 and LPN #2 had not notified the physician or sought treatment for Resident #1's rectal bleeding and the LPNs

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had administered enemas without physician's orders. According to the DON, both LPNs were suspended for one day. The Administrator stated upon completion of the investigation it was determined LPN #2's "actions were detrimental" to Resident #1 and the LPN was terminated on 05/03/11. According to the Administrator, on 06/24/11, the facility was informed by DCBS that DCBS' investigation found LPN #1 and LPN #2 guilty of caregiver neglect due to the failure to notify the physician concerning Resident #1's change in condition and for providing treatments without a physician's order. LPN #1 was suspended on 06/24/11. The interview revealed neither the Administrator nor the DON felt that LPN #1 or LPN #2 intended to neglect Resident #1 and stated, "The nurses used poor judgment." The Administrator stated the facility did not report the incident to DCBS because DCBS made the facility aware of the allegation. The Administrator confirmed the allegation was not reported to the Division of Licensing and Regulation/Office of Inspector General (OIG) because the facility had not considered the incident neglectful. The interview further revealed the investigation was not documented on the Resident Abuse Investigation Report form and interviews with staff had not been documented in accordance with the facility's policy.

*The facility implemented the following actions to correct the deficiency:

-All resident medical records were audited by the Director of Nursing (DON) and the Administrator on 04/22/11, related to reporting incidents of abuse/neglect.

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F 225	Continued From page 26 -All licensed nursing staff and state registered nursing staff was in-serviced on 06/03/11 and 06/21/11, regarding reporting abuse/neglect. -The Vice President of Clinical Operations reviewed and reiterated the facility's abuse/neglect prevention, investigating, and reporting policy with the facility Administrator and the DON on 05/17/11. -On 05/03/11, as part of the facility's ongoing quality assurance program, the 24-hour nursing reports and new physician's orders were reviewed daily in a meeting with the DON, the Administrator, the Minimum Data Set (MDS) Coordinator, and the Social Services Director to ensure residents received appropriate care/services and all abuse/neglect incidents were reported. -A weekly quality of care meeting is held every Thursday to review any resident with a change in condition, to ensure the residents have received the necessary care and services. This monitoring began on 05/03/11, and will be ongoing, to ensure that all abuse/neglect incidents are reported. **The surveyor validated the corrective action taken by the facility as follows: Interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed 100 percent of the residents' medical records were audited for reporting incidents of abuse/neglect, with no problems identified. Record review of eight resident's medical records revealed no neglect occurred that should have been reported.	F 225		

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F 225	Continued From page 27 Review of the facility in-service conducted on 06/03/11, with Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Medication Technicians (CMTs) revealed the licensed staff was in-serviced on the abuse/neglect policy. Review of a facility in-service on 06/21/11, with State Registered Nursing Assistants and three other facility staff members revealed they had been in-serviced on the abuse/neglect policy. Interviews with SRNA #1 on 07/27/11, at 3:15 PM; LPN #3 on 07/27/11, at 6:40 PM; RN #1 on 07/28/11, at 9:10 AM; LPN #4 on 07/28/11, at 9:20 AM; SRNA #2 on 07/28/11, at 2:57 PM; and SRNA #4 on 07/28/11, at 3:15 PM, revealed they had been in-serviced on the abuse/neglect policy. Interview with the DON, the Administrator, and the Minimum Data Set (MDS) Coordinator on 07/29/11, at 4:02 PM, and review of quality of care meeting minutes revealed they meet daily to review 24-hour nursing reports and new physician's orders to ensure residents received the necessary care/services and that any abuse/neglect allegations were reported and investigated. Interview with the Administrator and the DON on 07/29/11, at 4:02 PM, revealed they had been in-serviced on the abuse/neglect policy to include reporting and investigating any alleged abuse/neglect on 05/17/11, by the Vice President of Clinical Operations Executive. Review of minutes from the facility's meeting and interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed they had a quality	F 225		

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F 225	Continued From page 28 of care meeting, on a weekly basis, to discuss any resident who had experienced a change of condition and ensure appropriate care was provided.	F 225		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of Kentucky Revised Statute (KRS) 314.011, it was determined the facility failed to have an effective system to ensure staff provided services that meet professional standards of quality for one of nine sampled residents (Resident #1). The facility failed to ensure staff followed the Physician Orders policy/procedure to ensure all treatments/medications administered to residents were ordered by the physician. On 04/07/11-04/08/11, facility staff administered three "Soap Suds" enemas, one "Fleets" enema, and one-half of a bottle of "Citrate of Magnesium" to Resident #1 without a physician's order. Resident #1 experienced rectal bleeding for a timeframe of approximately 24 hours before/during and after the enemas/medication was administered, before being transported to the hospital on 04/08/11, due to rectal bleeding. Resident #1 was hospitalized on 04/08/11, diagnosed with rectal bleeding due to a rectal tear, and expired at the hospital on 05/07/11. This failure has caused, or is likely to cause,	F 281	Past noncompliance: no plan of correction required.	

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serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. The Immediate Jeopardy was determined to exist on 04/07/11, and continued until 06/22/11. The facility implemented corrective actions which were completed prior to the State Agency's investigation on 07/27/11, and as a result, Past Jeopardy was determined.

The findings include:

Review of KRS 314.011 revealed "Licensed Practical Nursing practice" means the performance of acts requiring knowledge and skill such as are taught or acquired in approved schools for practical nursing in: a) The observing and caring for the ill, injured, or infirm under the direction of a registered nurse, a licensed physician, or dentist; b) The giving of counsel and applying procedures to safeguard life and health, as defined and authorized by the board; c) The administration of medication or treatment as authorized by a physician, physician assistant, dentist, or advanced practice registered nurse; d) Teaching, supervising, and delegating except as limited by the board; and e) The performance of other nursing acts which are authorized or limited by the board.

A review of the facility's Physician Orders policy/procedures (dated 01/09/03) revealed all residents' medications/treatments were to be ordered by a licensed physician. The policy stated all medications administered to the resident must be ordered, in writing, by the resident's attending physician. According to the policy, medication, diets, therapy, or any other treatment may not be administered to the resident

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without the written approval from the attending physician.

Review of Resident #1's nurse's note dated 04/07/11, at 2:00 AM, revealed Resident #1 was having bright red rectal bleeding. The note revealed Resident #1 was checked by Licensed Practical Nurse (LPN) #2 for an impaction and a large amount of hard stool was noted. Documentation revealed a "Soap Suds" enema was administered by the nurse. The nurse's note dated 04/07/11, at 2:35 AM, revealed the resident had not had a bowel movement and the resident's rectum was "gapped open" with "some blood clolts (clots) noted." At that time, a "Fleets" enema was administered by LPN #2.

A review of the nurse's note dated 04/07/11, at 2:45 AM, revealed LPN #2 administered one-half of a bottle of 'Citrate of Magnesia' (laxative) through Resident #1's Gastrostomy tube. Continued review revealed a nurse's note dated 04/07/11, on the 7:00 AM-7:00 PM shift by LPN #1, which revealed the resident's rectum was noted to have "bleeding (spots)" and LPN #1 administered a "Soap Suds" enema.

Nursing documentation revealed on 04/07/11, at 9:30 PM, LPN #2 was summoned to Resident #1's room, the resident was observed to have a moderate amount of rectal bleeding, and the resident's rectum was "gaped open." The nurse checked the resident for an impaction and a large amount of soft to hard stool was noted in the lower bowel. LPN #2 documented a "Soap Suds" enema was administered and Resident #1 continued to have "bright red" bleeding from the rectum. A review of the medical record revealed

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there was no physician's order to administer the "Soap Suds" enemas, the "Fleets" enema, or to administer the 'Citrate of Magnesium." Documentation revealed Resident #1 was transferred to the hospital on 04/08/11, at 2:15 AM, due to rectal bleeding.

An interview conducted on 07/27/11, at 5:20 PM, with LPN #2 confirmed she had administered three enemas and "Citrate of Magnesium" to Resident #1 on 04/07/11-04/08/11. The LPN stated the facility had a bowel program which included interventions such as a "Soap Suds" enema, a "Fleets" enema, "Lactulose," and "Milk of Magnesia." LPN #2 stated she was unaware of the need for a physician's order to administer the interventions on the bowel program/protocol.

An interview was conducted with LPN #1 on 07/27/11, at 6:21 PM, and confirmed the LPN administered an enema to Resident #1 on 04/07/11. Interview with LPN #1 revealed the facility had a bowel protocol and she was unaware of the need for a physician's order to administer enemas.

Interviews conducted on 07/28/11, at 12:05 PM, and at 4:00 PM, with Resident #1's Primary Physician confirmed he was not contacted by facility staff related to the administration of enemas and/or medications (Laxatives) for Resident #1. The physician stated an enema should never be administered to a resident experiencing rectal bleeding.

An interview conducted on 07/27/11, at 5:45 PM, with the Director of Nursing (DON) revealed nursing staff was to follow the bowel protocol

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after receiving physician's orders for the treatment needed. According to the DON, it was the facility's policy never to administer any medications or treatments without a physician's order. The DON stated LPN #1 and LPN #2 were suspended for one day due to providing treatments without a physician's order.

A review of a Hospital Discharge Summary dated 05/26/11, revealed Resident #1 was admitted to the hospital on 04/08/11, due to rectal bleeding for two days. The summary revealed the resident received a blood transfusion upon admission. On 04/11/11, a colonoscopy was performed and revealed an ulcer and active bleeding coming from a large tear. The review revealed on 04/26/11, Resident #1 developed a slow heart rate, suffered cardiac/respiratory arrest, and expired on 05/07/11.

*The facility implemented the following actions to correct the deficiency:

-On 04/22/11, all resident records and bowel records were audited to ensure all treatments had appropriate physician's orders, with no problems identified.

-In-services were conducted on 04/15/11 and 05/04/11, by the Director of Nursing (DON) for all licensed nursing staff on obtaining physician's orders for all medications/treatments and the facility's bowel protocol.

-On 05/03/11, the facility initiated monitoring of the 24-hour nursing reports and new physician's orders to ensure all treatments had physician's orders. This was done daily during a meeting

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with the DON and the nurses on the floor, and will be ongoing.

-On 05/03/11, a quality of care meeting with the DON, the Administrator, the Minimum Data Set (MDS) Coordinator, and the Social Services Director was held weekly on Thursday, to identify residents that had received treatments to ensure there were physician's orders for the treatments. This monitoring will be done monthly.

**The surveyor validated the corrective action taken by the facility as follows:

Interview on 07/29/11, at 4:02 PM, with the DON and the Administrator revealed a 100 percent audit of resident charts had been completed on 04/22/11, to verify all treatments had proper orders by the physician documented. Review of eight residents' medical records revealed all treatments had the appropriate physician's orders.

Review of a facility in-service dated 04/15/11, revealed facility staff had been in-serviced on notifying the physician when a resident had a change of condition. Review of a facility in-service on 05/04/11, revealed facility staff had been in-serviced on obtaining physician's orders for treatments/medication and the need to notify the physician when a resident had a change in condition. Interview with the DON on 07/29/11, at 4:02 PM; Licensed Practical Nurse (LPN) #3 on 07/27/11, at 6:40 PM; Registered Nurse (RN) #1 on 07/28/11, at 9:10 AM; and LPN #4 on 07/28/11, at 9:20 AM, revealed facility staff had been in-serviced on the need to have a physician's order for all treatments/medication.

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F 281	Continued From page 34 Review of facility documentation and interview with the DON, the Administrator, and the MDS Coordinator on 07/29/11, at 4:02 PM, revealed they meet daily to review the 24-hour nursing report and new physician's orders to ensure any resident who received a treatment had a related physician's order. Review of minutes from the facility's meeting and interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed they had a quality of care meeting, on a weekly basis, to discuss any resident who had treatments had Physician's orders for the treatments.	F 281		
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to have an effective system to ensure staff provided the necessary care/services to maintain the highest practicable physical well-being for one of nine sampled residents (Resident #1). The facility failed to ensure staff followed the Changes in a Resident's Condition or Status policy/procedure to ensure the resident's	F 309	Past noncompliance: no plan of correction required.	

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physician was notified immediately when the resident experienced a significant change in condition and that a comprehensive assessment of the resident's condition was conducted. On 04/07/11, at 2:00 AM, Resident #1 experienced a significant change in condition of rectal bleeding and continued to have rectal bleeding until being transferred to the hospital 24 hours later, on 04/08/11, at 2:15 AM. The facility staff failed to notify the resident's physician of the resident's rectal bleeding and failed to conduct a comprehensive assessment of Resident #1. Resident #1 was hospitalized on 04/08/11, diagnosed with rectal bleeding due to a rectal tear, and expired at the hospital on 05/07/11.

The facility's failure to ensure each resident received the necessary care/services has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. Immediate Jeopardy was determined to exist on 04/07/11, and continued until 06/22/11. The facility implemented corrective actions which was completed prior to the State Agency's investigation on 07/27/11, thus the Immediate Jeopardy was determined to be Past Jeopardy.

The findings include:

A review of the facility's Changes in a Resident's Condition or Status policy/procedures (dated 01/09/03) revealed Nursing Services was responsible to notify the resident's attending physician when a resident experienced a significant change in physical status or when there was a need to significantly alter the resident's treatment. The policy revealed when a

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resident experiences a significant change in condition, the assessment coordinator would conduct a comprehensive assessment of the resident's condition.

A review of Resident #1's medical record revealed the facility admitted the resident on 01/19/10. Review of Resident #1's medication orders revealed the resident received Aspirin 325 milligrams (mg) once a day and Plavix 75 mg once a day (both anti-platelet agents used to inhibit blood clotting). Review of Resident #1's most recent Minimum Data Set (MDS) comprehensive assessment and Care Area Assessment (CAA) summary both dated 02/03/11, revealed the facility failed to address the resident's increased risk of hemorrhage (loss of blood) by the co-administration of Plavix and Aspirin.

Review of Resident #1's nurse's note dated 04/07/11, at 2:00 AM, revealed LPN #2 was summoned to the shower room due to Resident #1 having bright red rectal bleeding. The note revealed Resident #1 was placed onto the bed, checked for impaction with a large amount of hard stool noted, and a "Soap Suds" enema administered with small results noted.

The next nurse's note dated 04/07/11, at 2:35 AM, revealed the resident had not had a bowel movement and the resident's rectum was "gapped open" with "some blood clolts (clots) noted." The note documented a "Fleets" enema was administered by LPN #2. A nurse's note dated 04/07/11, at 2:45 AM, revealed LPN #2 administered one-half of a bottle of "Citrate of Magnesia" via Resident #1's Gastrostomy tube.

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Nursing documentation on 04/07/11, for the 7:00 AM-7:00 PM shift revealed LPN #1 assisted the resident to his/her left side, noted the resident's rectum was observed to have "bleeding (spots)," and a "Soap Suds" enema was administered. The documentation revealed Resident #1 continued to have bleeding at 2:00 PM, following the administration of the enema. On 04/07/11, at 9:30 PM, LPN #2 observed Resident #1 to have a moderate amount of rectal bleeding and the resident's rectum was "gaped open." LPN #2 administered a "Soap Suds" enema and noted Resident #1 continued to bleed from the rectum.

The next nurse's note, dated 04/08/11, at 1:45 AM, revealed Resident #1 had a large amount of blood clots from the rectum and the incontinence pad under the resident was "saturated." The review revealed Resident #1 was transported to the local hospital for evaluation of rectal bleeding on 04/08/11, at 2:15 AM. Based on a review of the documentation from 04/07/11, at 2:00 AM, until 04/08/11, at 2:15 AM, facility staff failed to notify Resident #1's physician of the significant change in the resident's condition and failed to conduct a comprehensive assessment.

An interview conducted on 07/27/11, at 5:20 PM, with Licensed Practical Nurse (LPN) #2 confirmed Resident #1 had rectal bleeding on 04/07/11 and 04/08/11. LPN #2 stated the resident's physician was out of town on 04/07/11-04/08/11, and stated the physician had not been informed of Resident #1's bleeding.

An interview conducted on 07/27/11, at 6:21 PM, with LPN #1 revealed on 04/07/11, she went to

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Resident #1's room and administered an enema due to observation of hardened stool in the resident's rectum. LPN #1 stated at approximately 2:00 PM on 04/07/11, Resident #1 had a bowel movement with a "few spots of blood" observed.

An interview conducted on 07/28/11, at 9:20 AM, with LPN #4 revealed he assessed Resident #1 on 04/08/11, and observed a moderate amount of bright red blood in the resident's incontinence brief. The LPN stated following his assessment Resident #1 was transported to the hospital for further assessment/treatment.

Interviews conducted on 07/28/11, at 12:05 PM and 4:00 PM, with Resident #1's Primary Physician revealed he expected nurses to report any change in a resident's condition, including bright red rectal bleeding. The physician stated Resident #1 received Aspirin and Plavix daily, which increased the resident's risk for bleeding, and would have been even more of a reason to report rectal bleeding to the physician. According to the physician, an enema should never be administered to a resident experiencing rectal bleeding.

An interview conducted on 07/28/11, at 10:10 AM, with the DON and the Administrator, revealed Administrative staff was unaware of the incident until 04/13/11; therefore, no comprehensive assessment was conducted.

*The facility implemented the following actions to correct the deficiency:

-All resident records were audited on 04/22/11, by

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the Director of Nursing (DON) and the Administrator related to physician notification/significant change in condition and assessments, with no concerns identified.

-In-services were provided on 04/15/11 and 05/04/11, for all licensed staff regarding physician notification/significant change in condition and assessments.

-A system was put into place on 04/22/11, for the DON to review the 24-hour shift report and new physician's orders, Monday through Friday, to ensure physician notification and assessments were appropriately performed. The charge nurse performs these duties in the DON's absence. This monitoring will be ongoing.

-Beginning on 05/03/11, as part of the facility's ongoing quality assurance program, the DON, the Administrator, the Minimum Data Set (MDS) Coordinator, and the Social Services Director will meet on a daily basis, Monday through Friday, to review the 24-hour nursing reports, and new physician's orders, in order to identify any resident with a change in condition, to ensure the physician had been notified of any changes in a resident's condition, and to ensure the appropriate assessments had been conducted.

-Beginning 05/03/11, a weekly quality of care meeting will be held every Thursday to review records of residents that had experienced a change in condition, wounds, weight loss, hydration issues, falls, and restraints to ensure the resident's physician had been notified and that assessments were conducted. This monitoring will be ongoing.

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-Quality assurance studies related to diagnostic tests and falls/restraints/physician notification and orders was conducted in May and June 2011, and will continue monthly for 12 months.

**The surveyor validated the corrective action taken by the facility as follows:

Interview on 07/29/11, at 4:02 PM, with the DON and the Administrator revealed 100 percent of resident charts were audited related to physician notification and assessment with no issues identified. Review of eight resident records revealed appropriate physician notification and assessments.

Review of facility in-services and interviews with the DON on 07/29/11, at 4:02 PM; LPN #3 on 07/27/11, at 6:40 PM; RN #1 on 07/28/11, at 9:10 AM; and LPN #4 on 07/28/11, at 9:20 AM, revealed they had been in-serviced on the need to notify the physician and the MDS Coordinator when a resident experienced a change in condition in order for a comprehensive assessment to be conducted.

Interview with the DON on 07/29/11, at 4:02 PM, and RN #2 (the weekend charge nurse) on 07/29/11, at 2:05 PM, revealed they reviewed the 24-hour shift reports and new physician's orders to ensure the necessary care/services were provided.

Review of facility meeting minutes and interview on 07/29/11, at 4:02 PM, with the DON, the Administrator, and the MDS Coordinator revealed they meet daily to review the 24-hour nursing shift

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F 309	Continued From page 41 reports and new physician's orders to ensure physician notification and assessments were conducted on any resident who experienced a change in condition. Review of minutes and interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed the facility had a weekly quality of care meeting to discuss any resident who had experienced a change of condition to ensure appropriate physician notification and assessments were conducted. Review of the facility Continuous Quality Improvement (CQI) and interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed during the months of May and June 2011, a quality assurance study was completed in the areas of diagnostic tests and falls/restraints, which included physician notification and physician's orders.	F 309		
F 490	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, it was determined the facility failed to be effectively/efficiently administered in a manner that maintained the highest physical	F 490	Past noncompliance: no plan of correction required.	

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well-being for one of nine sampled residents (Resident #1). The facility failed to have an effective system in place to ensure facility policies/procedures were implemented. The facility's Administration failed to ensure staff assessed and notified the physician when a resident experienced a significant change in condition. The Administration failed to ensure staff obtained a physician's order for treatments/medications prior to administering to residents. In addition, the Administration failed to ensure allegations of neglect were thoroughly investigated and reported to the appropriate state agencies.

On 04/07/11, at 2:00 AM, Resident #1 experienced a significant change in condition of rectal bleeding and continued to have rectal bleeding until transferred to the hospital 24 hours later, on 04/08/11, at 2:15 AM. The facility staff failed to notify the resident's physician of the resident's rectal bleeding and failed to conduct a comprehensive assessment of Resident #1 as per the facility's policy. The Administrator became aware of the neglect allegation on 04/13/11, when a representative from the Department for Community Based Services (DCBS) initiated an investigation involving Resident #1 and failed to thoroughly investigate and report the alleged neglect to the appropriate state agencies. Resident #1 was hospitalized on 04/08/11, diagnosed with rectal bleeding due to a rectal tear, and expired at the hospital on 05/07/2011. (Refer to F157, F224, F225, F281, and F309.)

This failure has caused, or is likely to cause, serious injury, harm, impairment, or death to

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Resident #1 and other residents in the facility. The Immediate Jeopardy was determined to exist on 04/07/11, and continued until 06/22/11. The facility implemented corrective actions which were completed prior to the State Agency's investigation on 07/27/11; therefore, the Jeopardy was determined to be Past Jeopardy.

The findings include:

A review of the facility's Changes in a Resident's Condition or Status policy/procedure (dated 01/09/03) revealed Nursing Services was responsible to notify the resident's attending physician when a resident had a significant change in physical status or there was a need to alter the resident's treatment significantly. The policy stated when a resident experienced a significant change in condition, the assessment coordinator would conduct a comprehensive assessment of the resident's condition.

A review of the facility's Physician Orders policy/procedures (dated 01/09/03) revealed all residents' medications/treatments were to be ordered by a licensed physician. The policy stated all medications administered to the resident must be ordered, in writing, by the resident's attending physician. According to the policy, medication, diets, therapy, or any other treatment may not be administered to the resident without the written approval from the attending physician.

A review of the facility's Resident Protection policy/procedure, with no date, revealed any alleged violation of neglect must be immediately reported to the Administrator or the DON.

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According to the policy, neglect was defined as the failure to provide goods/services necessary to avoid physical harm, mental anguish/illness. The review revealed upon receiving a report of neglect, the Administrator or the DON would immediately report the incident to the following agencies: Division of Licensing and Regulation/Office of Inspector General (OIG), Adult Protective Services, and other agencies as appropriate. The policy revealed the investigation should consist of the following: a) A review of the completed Incident Report Form; b) An interview with the person(s) reporting the incident; c) Interviews with any witnesses to the incident; d) An interview with the resident; e) A review of the resident's medical record; f) An interview with staff members (on all shifts) having contact with the resident during the period of the alleged incident; g) Interviews with the resident's roommate, family members, and visitors; and h) A review of all circumstances surrounding the incident. The review also revealed the facility would identify the potential for neglect by reviewing the daily nursing report forms, conducting nursing rounds, and routine observations.

Review of Resident #1's nurse's notes revealed LPN #2 observed Resident #1 on 04/07/11, at 2:00 AM, and noted the resident had bright red rectal bleeding. At 2:35 AM, documentation revealed the resident's rectum was "gapped open" with "some blood clolts (clots) noted." Resident #1 was also observed to have rectal bleeding at 2:00 PM on 04/07/11. A nurse's note dated 04/07/11, at 9:30 PM, revealed LPN #2 observed a moderate amount of bleeding from the resident's rectum, a "Soap Suds" enema was

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administered and the resident continued to have "bright red" bleeding from the rectum. A nurse's note dated 04/08/11, at 1:45 AM, revealed Resident #1 had a "large amount of blood clolts," and the pad underneath the resident was "saturated." The review revealed Resident #1 was transported to the local hospital for evaluation of rectal bleeding on 04/08/11, at 2:15 AM. Based on a review of Resident #1's medical record, there was no evidence facility staff attempted to notify the resident's physician of the significant change in the resident's condition from 04/07/11, at 2:00 AM, until 04/08/11, at 2:15 AM. The documentation revealed there was no assessment of Resident #1 on 04/07/11, from 2:00 PM until 9:30 PM, and then no further assessment of the resident until 1:45 AM on 04/08/11.

Interviews conducted on 07/28/11, at 10:10 AM, 12:30 PM, and 3:20 PM, with the Vice President of Clinical Operations, the Director of Nursing (DON), and the Administrator revealed the Administrator and the DON became aware of an allegation of neglect when a representative of DCBS initiated an investigation on 04/13/11, related to Resident #1. The interviews revealed administrative staff reviewed Resident #1's medical record and interviews were conducted with the staff involved in the resident's care. Based on the facility's investigation, it was determined LPN #1 and LPN #2 had not notified the physician of a change in Resident #1's condition and had administered enemas without a physician's order. According to the Administrator and the DON, "the nurses used poor judgment." The Administrator stated the facility did not report the incident to DCBS because DCBS made the

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facility aware of the allegation. The Administrator confirmed the allegation was not reported to the Division of Licensing and Regulation/Office of Inspector General (OIG) because she did not consider the incident neglectful. The interview revealed every morning, Monday thru Friday, the DON met with the nurses, reviewed the 24-hour shift report, and observed all residents in an effort to identify concerns related to the residents. According to the DON, she attempted to ensure the appropriate care/services were provided and to ensure the physician was notified of any changes in a resident's condition. The interviews revealed the DON was on vacation the week of the incident and there was no backup system in effect to perform the duties of the DON in her absence.

Review of the facility's investigation revealed a timeline of the incident had been documented but the facility's investigation failed to include interviews with staff involved in provision of care to Resident #1 during the time of the allegation. In addition, the facility's investigation did not indicate the allegation had been reported to the appropriate state agencies.

*The facility implemented the following actions to correct the deficiency:

-All resident records were reviewed on 04/22/11, by the Director of Nursing (DON) and the Administrator to ensure all incidents of neglect were reported/investigated and that care provided met professional standards and facility policies.

-On 05/17/11, the Vice President of Clinical Operations reviewed and reiterated the facility's

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F 490	Continued From page 47 Resident Protection policy, including investigating and reporting of neglect allegations, with the Administrator and the DON. -All licensed nursing staff was in-serviced by the DON and the Administrator on 06/03/11 and 06/21/11, regarding abuse prevention, investigation, and reporting. -The facility conducted in-services on 04/15/11 and 05/04/11, for all licensed staff regarding physician notification when a resident experienced a change in condition. -A system was put in place on 04/22/11, and required the DON to review the 24-hour shift report and new physician's orders on Monday through Friday, to ensure appropriate care was provided and neglect did not occur. On the weekends the charge nurse performs the tasks. This monitoring system will be ongoing. -As part of the facility's ongoing quality assurance program, the 24-hour nursing reports and new physician's orders were reviewed daily in a meeting with the DON, the Administrator, the Minimum Data Set (MDS) Coordinator, and the Social Services Director to identify any resident with a change in condition and assure the physician was notified, appropriate care/services were provided, and any neglect issues were reported to Administration. This process began on 05/03/11. -The department heads will participate in a weekly quality of care meeting on Thursdays to review any resident with a change in condition to ensure the residents have received the necessary	F 490		

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care and services. This process began on 05/03/11, and will be ongoing.

-All investigations will be reviewed by the Medical Director within two working days of completion and reviewed in the monthly quality assurance meeting to ensure all components of abuse/neglect prevention, investigation, and reporting were met.

**The surveyor validated the corrective action taken by the facility as follows:

Interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed 100 percent of the residents' medical records were audited for reporting incidents of abuse/neglect, with no problems identified. Review of eight resident records revealed appropriate physician notification and assessments.

Interview on 07/29/11, at 4:02 PM, with the DON and the Administrator revealed they had been in-serviced on 05/17/11, on the facility abuse/neglect policy regarding investigating and reporting by the Vice President of Clinical Operations.

Review of the facility in-service conducted on 06/03/11, with Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Medication Technicians (CMTs), revealed the licensed staff was in-serviced on the abuse/neglect policy. Review of a facility in-service on 06/21/11, with State Registered Nursing Assistants and three other facility staff members revealed they had been in-serviced on the abuse/neglect policy. Interviews with SRNA

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#1 on 07/27/11, at 3:15 PM; LPN #3 on 07/27/11, at 6:40 PM; RN #1 on 07/28/11, at 9:10 AM; LPN #4 on 07/28/11, at 9:20 AM; SRNA #2 on 07/28/11, at 2:57 PM; and SRNA #4 on 07/28/11, at 3:15 PM, revealed they had been in-serviced on the abuse/neglect policy.

Review of a facility in-service conducted on 04/15/11 and 05/04/11, revealed all licensed staff was in-serviced on physician notification when a resident had a change in condition. Interviews on 07/29/11, at 4:02 PM, with the DON; on 07/27/11, at 6:40 PM, with Licensed Practical Nurse (LPN) #3; on 07/28/11, at 9:10 AM, with RN #1; and on 07/28/11, at 9:20 AM, with LPN # 4 revealed they each had attended an in-service training.

Review of minutes from the facility's meetings, including quality of care meeting, and interview with the DON, the Administrator, and the MDS Coordinator on 07/29/11, at 4:02 PM, revealed they had met daily to review 24-hour nursing reports and new physician's orders to monitor for residents' change of condition and physician notification to ensure any abuse/neglect allegations were reported and investigated.

Interview with the DON on 07/29/11, at 4:02 PM, and RN #2 (weekend charge nurse) on 07/29/11, at 2:05 PM, revealed they reviewed the 24-hour shift reports to ensure appropriate care was provided and no incidents of abuse/neglect occurred. A form was provided for review by the DON; however, the DON stated she had not begun using the form to review the shift reports.

Review of minutes from the facility's meeting and interview with the DON and the Administrator on

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F 490	Continued From page 50 07/29/11, at 4:02 PM, revealed they had a quality of care meeting on a weekly basis to discuss any resident who had experienced a change of condition and ensure appropriate care was provided. Interview with the DON and the Administrator on 07/29/11, at 4:02 PM, revealed the Medical Director would review any investigations of abuse/neglect within two working days; however, there had been no reports of abuse/neglect and there were no reports to review.	F 490		